

For Optional Use

SCHEDULED DELIVERY

Scheduled is defined as any artificial initiation of labor or cesarean birth in a woman not in labor regardless of when it was scheduled.

(Note: if pregnancy with multiple births, one form can be used)

Facility Name: _____ Delivery Date/Time: __ / __ / ____ / ____ Primary Care Provider Completing Form _____

Scheduled Delivery was:

- Induced Labor
 - Resulted in Vaginal Delivery
 - Resulted in C-Section
- Scheduled C-Section _____ Primary _____ Repeat

Gestational Age _____ (GA at time of scheduled delivery)

Please indicate how gestational age was determined and documented: (Please select one)

- Ultrasound < 20 weeks that confirmed or established due date
- Ultrasound between 20 and 28 weeks that confirmed or established due date
- Ultrasound after 28 weeks
- LMP / Menstrual History alone (without U/S data)
- _____ weeks since a positive serum or urine human chorionic gonadotropin pregnancy test
- Fetal Heart Tones identified by Doppler for ____ weeks, or by Auscultation for ____ weeks
- Other / no dates

Was fetal lung maturity proven by amniocentesis? Yes No (Fetal lung maturity established prior to 39 weeks, in the absence of appropriate clinical circumstances, is not an indication for delivery ACOG, 2009)

Is there documentation in the medical record that the risks, benefits, alternative approaches and indications for scheduled delivery were discussed with the mother? Yes No

Reason(s) and supportive clinical evidence documented in medical records for scheduled delivery (check all that apply):

- Maternal Indication (please list all) _____
- Fetal Indication (please list all) _____
- Social Indication (Gestational Age of 39 completed weeks gestation should be documented in most cases) _____
- No Indication (Gestational Age of 39 completed weeks should be documented) _____
- Other _____

Did the infant go to the Special or Intermediate Care Nursery or the NICU?

- Yes No

(If multiple birth, answer yes if ANY of the babies went to a Special or Intermediate Care Nursery, or NICU).

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If Labor was Induced,

- Bishop Score = _____** (≥ 8 is favorable; please indicate parameters in medical record) ***The use of cervical ripening agents is discouraged for inductions without a medical indication**
- Fetal Well Being Established** ___Yes___No (If no, document justification for induction of labor)
- Fetal presentation assessed and documented**
- Pelvic exam assessed and documented**

(12-11-09 OPCE)